



In collaboration with Cain Associates, LLC

Prioritizing Community Based Services in CT

How investing in the cost of care for health and human services strengthens families, community and the state economy.

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Executive Summary

Community providers are critical partners to the state of Connecticut, providing high quality health and human services to more than 500,000 people each year. Community providers save lives, while being less costly than state-provided services, yet Connecticut has struggled to make community-based services a budgeting or policy priority. Medicaid reimbursement rates do not cover the cost of care, leaving providers to operate at a loss for nearly every service delivered. Ever-increasing costs and demand for services, combined with repeated budget cuts, have put the provision of critical services at risk.

The Connecticut Community Providers Association (CCPA) commissioned an independent, nationally distinguished organizational consultant, MTM Services, to study the true cost of care compared to revenues of private providers. As expected, findings in this report show that chronic underfunding has taken a significant toll on community providers.

Among the behavioral health services, for example, which are reimbursed through a Medicaid Fee for Services (FFS) delivery system, rates are so low that behavioral health providers lose more than \$27 million every year in the underfunding of the most utilized services, accounting for 75 percent of total service hours. At the same time, mental health and substance abuse grants for the uninsured faced a whopping \$25 million cut to state funding in fiscal year 2015 that would destabilize the mental health system in Connecticut. While a portion of those funds were restored in the final budget with one-time funds, it is unclear how they will carry forward in the Fiscal Year (FY) 16 budget.

Providers in the state's Medicaid waiver/per diem-based delivery system for disability services are also experiencing losses in every service. For example, nine providers of 24-hour residential supports lose a total of \$8 thousand per day. Worse, at a time when all providers are struggling to make ends meet, the state has implemented a new rate system designed to create uniformity of reimbursement rate that increases rates for some providers by reducing the rates of others.

While there may be multiple strategies to support the clients served by Connecticut's community providers, the most obvious and effective is to provide funding that covers the cost of care:

- Medicaid reimbursement rates, whether in the form of CPT codes or per diem waiver-based rates, must be increased to reflect the current costs of appropriate levels of care.
- OPM should conduct an analysis comparing the cost of state services used by community provider employees to the state budget savings in funding reductions for private providers.
- To support the goal of cost-based funding for services, the state must maximize federal reimbursement. Services that are not reimbursed through current state Medicaid plans, but could be if negotiated appropriately at the federal level, should be considered.
- The state must maintain DMHAS and DCF grants, as these funding streams are critical to a stable system of care.

Introduction

Community providers are critical partners to the state of Connecticut, providing high quality health and human services to over 500,000 people each year. Providers support Connecticut's residents, and can even help to prevent tragedies when given the opportunity to offer the appropriate services at the appropriate time. In every area, from mental health to substance use disorders, developmental disabilities to child and family health and well-being, Connecticut providers are mainstays in their communities and key to the delivery of cost-effective, high quality health and human services.

In difficult and uncertain economic times, families and individuals still need services, perhaps more than ever. Community providers save lives, while being less costly than state-provided services, yet Connecticut has struggled to make community-based services a budgeting or policy priority. Providers have been chronically underfunded for years. A FY 2013 .5% cost of living adjustment (COLA), implemented in January 2014, was annualized to 1% in FY 2014. This increase was effectively wiped out by concurrent rescission and deficit mitigation cuts. According to a 2009 report by the Governor's Cabinet on Nonprofit Health and Human Services, nearly three quarters of the nonprofit agencies in the state with budgets of at least \$1 million were in deficit in 2009, compared with 40 percent nationally. It is common for providers to operate on negative margins and risk closure with any unexpected cut or financial reversal. This reality is set against a backdrop of ever-increasing costs and need for services.

In 2010, following passage of the federal Patient Protection and Affordable Care Act (ACA), Connecticut was one of the first states to expand its Medicaid low income adults (LIA) program. As of January 1, 2014, the state expanded its LIA population to include individuals making up to 138% of the poverty level, in accordance with an expected 100% reimbursement from the federal government, per the ACA. This reimbursement will decline slowly down to 90% by 2020.

The Governor's 2013-2014 biennial state budget proposed a significant reduction in state funding for behavioral health services by private community providers. The reduction was based upon an assumption that expanding Medicaid populations, and a LIA reimbursement at 100% (instead of Connecticut's FMAP rate of 50%¹) would reduce the need for state funding. In fact, this assumption is incorrect, as the Medicaid expansion has created significant losses due to inadequate Medicaid rates and concurrent cuts to state funding. Medicaid rates do not cover the real cost of care. Private community providers – who care for some of the most financially vulnerable and needy residents of our state – operate at a loss under Medicaid rates for nearly every service provided.

Some have argued that private community providers are not as critically underfunded as they claim, as they continue to stay in business. However, the reality is that they remain in business by offering no raises, reducing employee benefits, laying off staff, or cutting supplementary programming. Community providers are mission driven and highly committed to serving the neediest populations, driving them to make these sacrifices in the name of the services they

provide. But this approach leads to unsustainable losses. As with any solvent business model, increasing losses ultimately drive providers to reach a tipping point, and the state is there.

In the context of this financial crisis, the Connecticut Community Providers Association (CCPA) commissioned an independent, nationally distinguished organizational consultant, MTM Services, to study the real cost of care versus revenues of private providers. As expected, findings interspersed throughout this report illustrate the chronic underfunding of community providers. If Connecticut is to avert a complete destabilization of the system of care for health and human services, providers must be reimbursed for the true cost of care. The state does not expect contractors for transportation and infrastructure to complete projects without fully funding them; nor should providers of critical human services be expected to operate at a loss.

Community based services are essential to the well-being of individuals and families. Access to quality services improves the safety and security of Connecticut's communities and contributes significantly to the state economy. This brief will address the funding crisis for private community providers, as well as offer recommendations for prioritizing the provision of health and human services in Connecticut, a win-win proposition for all stakeholders.

Behavioral Health Services

Community behavioral health providers are primarily funded through Connecticut's Medicaid program, which is structured as a fee for service (FFS) delivery system that reimburses providers a set rate for each unit of service provided to a Medicaid consumer. State dollars used for Medicaid services are reimbursed at a 50% rate by the federal government. In recent years,

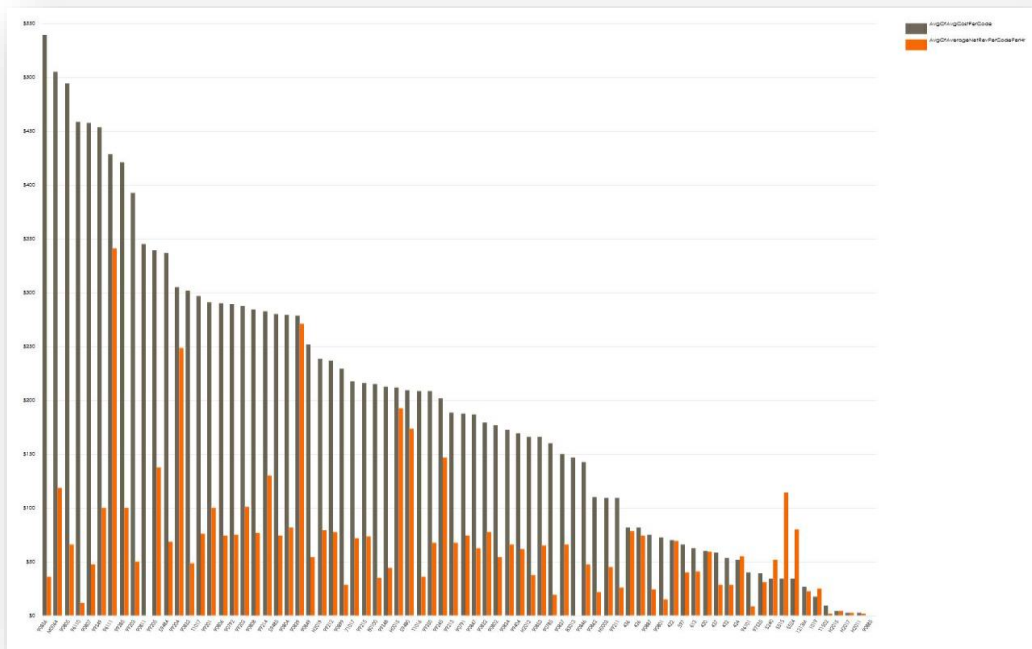


Figure 1: Average Cost Versus Revenue Per CPT Code/Per Hour

Connecticut's behavioral health service delivery system has evolved significantly. Providers employ innovative, sophisticated services focused on the integration of substance abuse, mental health, and primary care services. Services are increasingly provided in the community through a family-centered, wraparound approach. Despite provider investments in advancing the service delivery system and ever-increasing operational and administrative costs, Medicaid rates remain grossly inadequate and do not, as Figure 1 demonstrates, come close to covering the true cost of care in the vast majority of service areas.

The difficulty with operating in a fee for service system is Medicaid reimbursement rates are the sole source of revenue for providers serving Medicaid clients. With inadequate reimbursement rates, the state not only fails to maximize its federal matching funds, it risks the provision of some of the most highly utilized, critical behavioral health services. These are the very services with some of the largest cost versus revenue margins. A sampling of some of the most essential services for which providers are under-reimbursed illustrates just how at-risk Connecticut's residents are to losing access to services. Figure 2 represents an analysis of the top 10 services by their Medicaid Current Procedural Terminology (CPT) codes, arranged by volume of services provided to illustrate how *the top 10 most utilized behavioral health services account for seventy five percent of total service hours. Annually, providers lose a total of \$27,304,124 from the provision of just ten essential services.*

	CPT Code	Total Hours	% of Hours	Average of Average Cost per Code	Average of NET Revenue per Code Per Hour	Margin Per Hour	Total Loss for All Hours	
1	90834	68,247.69	21%	\$172.93	\$66.07	(\$106.86)	(\$7,293,001)	Top 10 Total Hours
2	H2019	33,273.97	10%	\$213.49	\$80.24	(\$133.25)	(\$4,433,723)	248,698.34
3	90837	29,728.17	9%	\$146.56	\$65.70	(\$80.86)	(\$2,403,873)	
4	90847	28,005.69	8%	\$187.03	\$62.28	(\$124.75)	(\$3,493,774)	Top 10 Total Hours
5	90791	25,531.92	8%	\$187.17	\$75.19	(\$111.98)	(\$2,859,141)	75%
6	90853	16,232.32	5%	\$165.38	\$62.27	(\$103.12)	(\$1,673,798)	
7	H2012	15,693.57	5%	\$166.20	\$37.61	(\$128.58)	(\$2,017,936)	Top 10 Total Hours
8	99213	12,798.70	4%	\$180.97	\$64.31	(\$116.66)	(\$1,493,098)	(\$27,394,124)
9	H0015	10,962.83	3%	\$198.28	\$196.52	(\$1.76)	(\$19,336)	
10	T1017	8,223.48	2%	\$283.56	\$76.05	(\$207.51)	(\$1,706,445)	

Figure 2: Analysis of the top 10 CPT Codes by Volume: 75% of All Service Hours

Psychotherapy (90834) is an essential service used to augment other approaches (e.g. group) for individuals most in need of services, and is a valuable part of the treatment package. Moreover, many clients are “dropped down” to outpatient psychotherapy when higher levels of care are not available or not approved. Psychotherapy accounts for 21% of all service hours, with providers losing an average of \$106.86 per hour of service rendered.

In-home therapeutic services (H2019) include clinical services provided in a client's home and community, accounting for approximately 10% of all service hours. One such in-home program, Multi-Dimensional Family Therapy (MDFT), offers intensive clinical services and support to children and youth returning from out-of-home care or who are at risk of requiring out-of-home care due to substance abuse or co-occurring disorders. For each hour of service rendered, a provider loses \$133.25.

Family Psychotherapy (90847) encompasses a variety of methods focused on the family unit, including the individual member in the session. Family psychotherapy is a critical component to treatment, as it improves the functioning of the entire family unit rather than the single individual. Accounting for approximately 8% of all service hours rendered, providers administering family psychotherapy lose an average of \$124.75 an hour.

According to a 2014 Medicaid Expenditure Report by the Connecticut Department of Social Services, an additional 123,249 consumers enrolled in Medicaid following the state's Medicaid expansion. As previously noted, this expansion was presumed to generate additional revenue for providers. However, in practice, an increasing number of Medicaid clients only widens the ever-increasing gap between the actual cost of services and inadequate Medicaid rates.

In addition to Medicaid reimbursements, mental health and substance abuse providers receive funding in the form of grants for the uninsured from the state Department of Mental Health and Addiction Services (DMHAS). DMHAS grants are a critical source of revenue for providers and face significant uncertainty at this time. The faulty premise regarding revenue from the Medicaid expansion, as discussed above, resulted in a proposed \$25 million cut to DMHAS grants in FY 2015. Such a cut would have destabilized the system, but the legislature restored \$10 million from the Tobacco Settlement Fund as a one-time solution. DMHAS worked with providers to keep them whole as long as possible, but recently significant cuts have become unavoidable. The legislature also appropriated a net \$4.15 million for an increase in Medicaid rates, which has not yet been submitted to the Centers for Medicare and Medicaid Services (CMS) for approval. Together, these are critical holes in the funding system for community-based behavioral health.

Individuals and families in need of critical behavioral health services do not simply disappear if care is no longer available. Instead, they may seek exponentially more expensive services in emergency departments or worse, not at all. They may end up in jails, become homeless, or become a danger to themselves and others. The human, community safety, and economic costs of funding reductions are difficult to measure, but they are real, and they dwarf the cost of funding cuts.

Impacts on Staffing and Specific Areas of Service Delivery

The cost study conducted by MTM Services demonstrated in multiple ways the impact of underfunding on the provision of health and human services in the private sector. Figure 3 shows the total dollar loss (in millions) of all hours per CPT code. The greatest loss in revenue occurs in outpatient psychotherapy (CPT Code 90834), a critical service for many individuals with mental health disorders, whether as a first step in treatment, or a step-down from more intensive levels of care. With such a disparity in costs and revenues, however, it is clear that outpatient services are at severe risk in an underfunded environment, with no change in Medicaid reimbursement rates and both real and potential cuts to state funding.

Figure 3 represents the top 23 CPT codes, representing 96% of the total service hours, amounting to \$34.3 million in losses. Not only must private community providers analyze their ability to stay in business based on the services that are draining their resources, they must also make difficult decisions about the personnel for which they are experiencing the greatest losses.

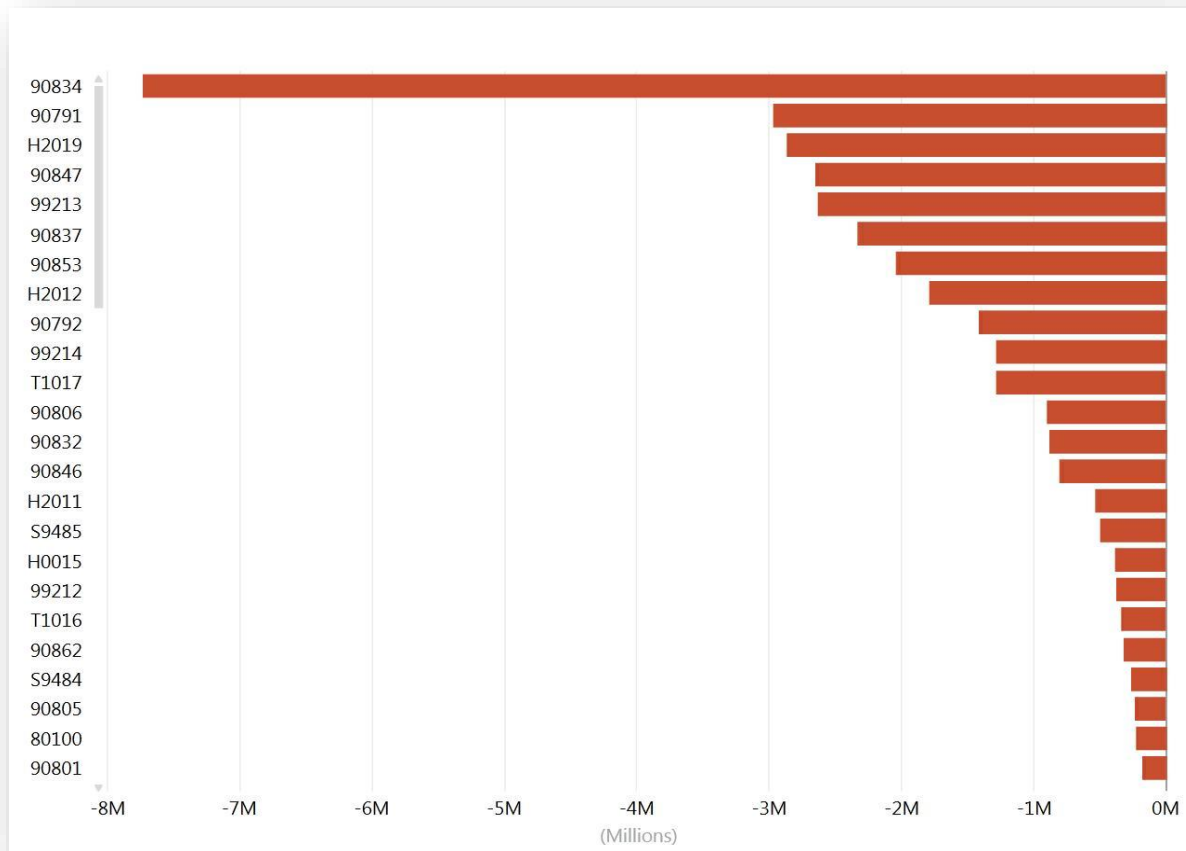


Figure 3: Total Dollar Loss (in millions) of All Hours by CPT Code

Figure 4 is a snapshot of the most common types of service providers employed by community providers. Medical doctors, most notably psychiatrists, are the most expensive, followed closely by Advanced Practice Registered Nurses (APRNs) and Registered Nurses. These positions are responsible for delivering some of the most high quality and essential behavioral health services, such as medication prescription and management, which help to maintain individuals in the community. They are also critical to the delivery of some of the most underfunded services, as demonstrated by CPT codes in Figure 3. These positions will never see the economy of expense that others such as Substance Abuse counselors do, who serve clients in a group setting rather than a one-to-one basis.

After administrative and operational efficiencies are exhausted, remaining budget shortfalls must be resolved by laying off staff, as they near the tipping point of program closures. Eliminating critical positions such as APRNs or psychiatrists will continue to have a deleterious impact on access to care. Closing outpatient clinics, as many providers are considering, will also have a dramatically negative effect on access to care for the neediest individuals and families in

the state. As only one example, in 2015, a provider experiencing a 12.5% reduction in DMHAS grant accounts calculated they would be forced to lay off two full time APRNs, who carry caseloads of 400 clients each. The elimination of these positions would have reduced access to medication management for 800 clients.

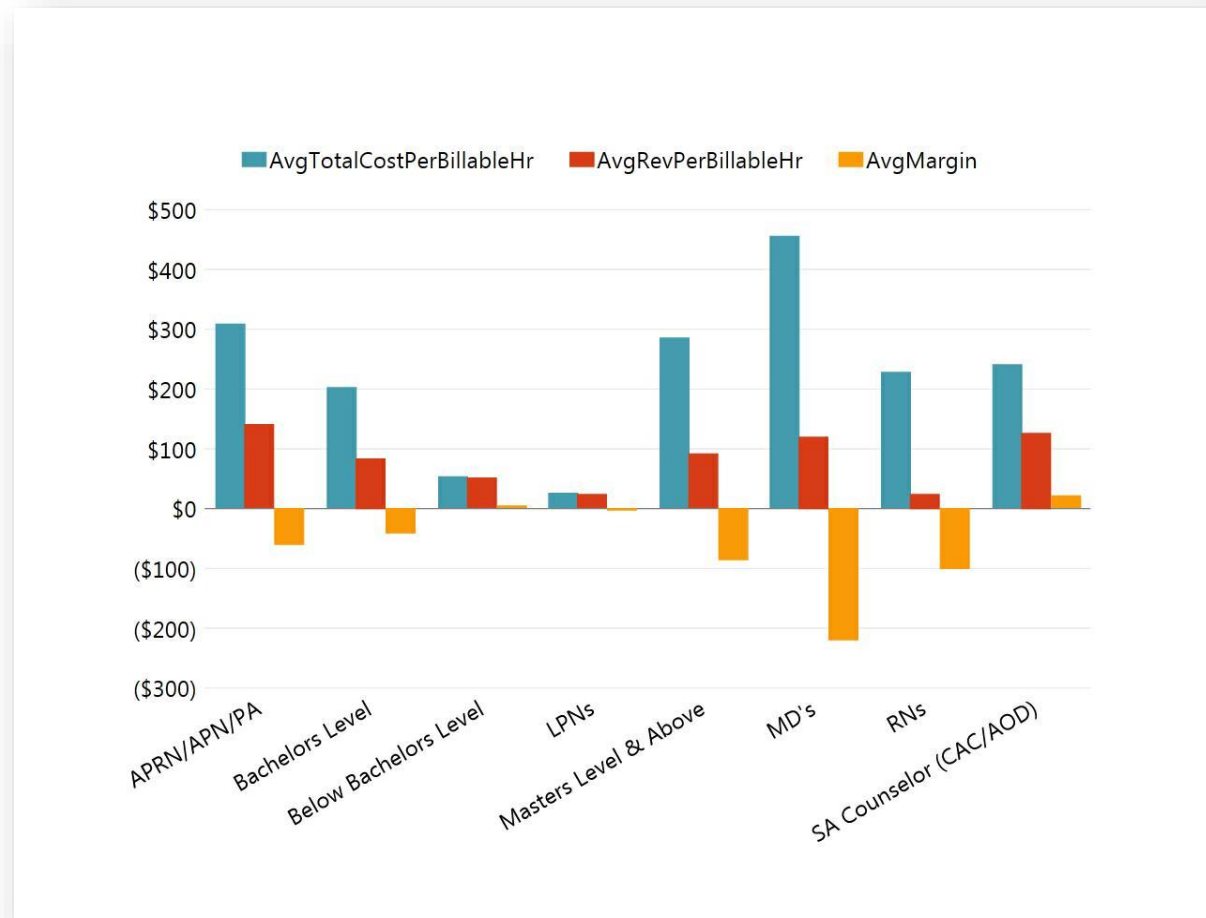


Figure 4: Average Loss of Hours by Individual Position

Today, community providers are forced to push direct care staff wages closer and closer to minimum wage, offering few or no benefits – they can no longer afford to offer robust benefit packages as compared to the state. Unable to secure adequate wages and benefits from their employers, staff often have no choice but to work multiple jobs to make ends meet. Anecdotal data from providers indicates that as many as one third of their employees receive healthcare through Connecticut's HUSKY Health (Medicaid) program, costing the state valuable resources in the long run. Furthermore, the reality is that private providers often expend considerable resources recruiting and training staff, only to lose them to state agencies that can offer much higher salaries. These conditions cause high turnover rates, contributing to instability in a system reliant on continuous relationships between staff and clients.

Connecticut has a wide network of highly skilled and experienced mental health professionals working in clinic and community based settings, providing services in accordance with best practices and evidence-based programs designed to meet the multiple and diverse needs of adults, children, and families. Funding, however, is simply not adequate to ensure they can serve all individuals and families who need them. The stability of the system is at risk.

Developmental Disability Services

Much the same as in the behavioral health system, rates of reimbursement for providers of services to individuals with disabilities are inadequate to cover the cost of care. Due to the difference in the structure of the reimbursement system, the picture looks slightly different, but the reality for providers as service deliverers is the same. In the developmental disability (DD) system, providers are reimbursed on what is considered to be a “per diem” basis, receiving monthly lump sum payments per consumer, rather than a reimbursement for smaller units of each service provided. This reimbursement is brought to providers through Medicaid under Home and Community-Based Services (HCBS) waivers. As in the behavioral health system, state dollars are matched at approximately fifty percent by federal Medicaid dollars.

Under the per diem system, measures of average losses among providers are sometimes more difficult to pinpoint than in the FFS system. This is compounded by a reimbursement system that sets rates based on current levels of appropriation, rather than actual measures of costs and necessary levels of service. By doing so, the system often paints the picture that provider costs do not far outweigh reimbursements, while the reality is that providers simply are not given the opportunity to *show* true costs. Instead, they are forced to maintain low wages and poor benefits packages for their staff in order to fit within the state’s allotted authorizations.

However, even with these factors falsely driving a snapshot of margins down, many providers experience quantifiable losses that further jeopardize the services that they deliver. In the study conducted by MTM Services, 13 CCPA providers of services to individuals with disabilities demonstrated the following losses:

Category of Service	# Providers	Average Census Per Day	Total Gain/(Loss) Per Day
Community Companion Homes	3	40	(\$125.43)
Community Living Arrangements	9	753.74	(\$8,195.98)
Day/Employment Services	12	1817.57	(\$7,436.76)
Individualized Home Supports	8	218.89	(\$462.04)
Intermediate Care Facilities	2	209	(\$500.81)

Figure 5: Summary of Gains/Losses per Day by DD Provider Service Category

Magnifying these losses is the rate transition process currently impacting providers, especially those offering day/employment and residential services. The Department of Developmental Disabilities (DDS) has historically negotiated service contract authorizations (“rates”) separately

with each provider as they begin offering services; with the fluctuation of the economy and changing state leadership, this has created a system of disparate rates of provider reimbursement for services. In 2005, a legislative rate study committee determined that a uniform rate must be set for each service to comply with federal HCBS waiver requirements. It was determined that these rates would be utilization-based and would be founded on each individual's Level of Need (LON) score.

Following a multi-year rate setting process, the new rates were essentially determined by dividing the current total appropriation for each type of community-based service by the current needs in the system. These numbers were then used to determine an average hourly wage for Direct Support Professionals, which serves as the foundation for the rates, along with adjustments for supervision, clinical/nursing, staff benefits, staff substitute days, indirect costs, and administrative/general expenses.

Rate Methodology for Day Support Option/Group Supported Employment	
	<i>Hourly Cost</i>
Foundation: Hourly Rate	\$14.75
Adjustments	
Adjusted hourly rate for a 35 hour week	\$17.90
Supervision factor of 29%	\$5.19
Substitute staff for 15 days of direct care absences	\$1.03
Employee benefits rate of 26.35%	\$6.36
Indirect Expenses including Clinical and Nursing factor of 40%	\$9.83
Administrative & General Expenses factor of 12%	\$4.84
Total Cost for CLA/CRS Supports	\$45.14
Adjust for three individuals supported by one staff	\$15.05
Hourly Rate Adjusted for 90% Attendance	\$16.72

Rate Methodology for CLA/CRS Supports		
<i>Example: annual authorization for an individual with a LON of 5 living in a 4 bed CLA</i>		
	<i>Hourly Cost</i>	<i>Share of the Annual Authorization</i>
Foundation: Hourly Rate	\$14.08	\$37,923
Adjustments		
Supervision factor of 25%	\$3.52	\$9,481
Nursing/Clinical factor of 11.9%	\$2.10	\$5,651
Substitute staff for 30 days of direct care absences	\$2.03	\$5,461
Employee benefits rate of 26.35%	\$5.79	\$15,600
Indirect Expenses factor of 13.5%	\$2.16	\$5,813
Administrative & General Expenses factor of 10.7%	\$3.18	\$8,552
Total Cost for CLA/CRS Supports	\$32.85	\$88,481

Figure 6: DDS Rate Methodologies for Day and Residential Services

The rate scales were tied to LON scores and, in the case of residential rates, the number of individuals in the residential setting:

Beds	LONS							
	1	2	3	4	5	6	7	8
1	25,256	33,665	67,260	89,681	117,734	180,314	194,702	207,891
2	25,256	33,665	67,260	89,681	117,734	123,730	136,519	152,583
3	25,256	33,665	67,260	89,681	102,470	116,090	132,522	150,185
4	25,256	33,665	67,260	75,454	88,481	102,101	128,326	147,787
5	25,256	33,665	57,046	68,260	80,688	98,504	126,527	145,389
6	25,256	29,253	51,450	63,863	77,690	94,907	122,930	139,394
7	21,420	26,855	46,768	57,383	66,899	82,917	109,741	133,398
8	20,221	25,656	42,657	54,385	63,302	78,121	103,746	126,204

Figure 7: DDS LON-Based Rates for CLA/CRS Services

While this accomplished the goal of a developing a uniform system, without additional funding it necessitated a rebalancing among providers, in which some providers (“under-the-rate” providers) would receive increases at the expense of others (“over-the-rate” providers), who would receive cuts to ensure a balance within the current level of appropriation. This methodology did not account for any variation among the salaries and wages historically paid by providers, which is a key element of provider costs. In other words, there is no connection to the historical cost of provider services. This methodology is contrary to every other cost reimbursement system in the state. In fact, there have been cases in which the state has not been allowed to lower a Medicaid rate unless it can show a corresponding reduction in the provider cost of delivering services.

The seven-year implementation process began on January 1, 2012 for day services:

Sheltered Workshop Rates			GSE/DSO Rates		
LON	Annual Rate	Hourly Rate	LON Overall Day or Behavior	Annual Full-Time	Hourly Rate
1	\$9,464	\$7.01	1	\$11,286	\$8.36
2	\$11,367	\$8.42	2	\$15,053	\$11.15
3	\$13,257	\$9.82	3	\$18,806	\$13.93
4	\$15,147	\$11.22	4	\$20,696	\$15.33
5	\$18,927	\$14.02	5	\$22,572	\$16.72
6	\$20,817	\$15.42	6	\$24,449	\$18.11
7	\$22,707	\$16.82	7	\$26,339	\$19.51
8	\$24,597	\$18.22	8	\$28,215	\$20.90

Figure 8: DDS LON-Based Rates for Day Services

The implementation process was delayed to January 1, 2015 for residential services. During this lapse, DDS experienced cuts in the FY 14 budget, which were passed on to residential providers. As the rates had not yet been finalized, over \$10 million was taken out of the residential system, driving per person rates down once again. In a system already stretched thin after years of flat funding in the face of increasing costs, this final step was felt as a tremendous cut to the system,

as “over-the-rate” providers looked at increasing reductions and “under-the-rate” providers faced diminishing increases.

Even more recently, DDS experienced a total \$5 million cut from day/employment services in FY15 budget rescissions, and an overall \$13.8 cut to the agency, the hardest hit agency by the two sets of rescissions (November 2014 and January 2015). Though not yet final, providers have been warned by the Department that the rates for day services will be impacted. This is compounded by an ongoing transition that requires day providers to extend their program operations by one half hour per day without an increase in daily rates.

Impacts on Staffing and Specific Areas of Service Delivery

Against a backdrop of chronic underfunding, the rate transition process has exacerbated several issues. First, while DD providers have historically operated at varying cost levels, they have all suffered in the recent climate of increasing costs without rate increases. None have been able to offer reasonable wage increases to their staff, leading to even higher rates of turnover, and all have experienced the mounting pressures of increasing health care and other costs in recent years. However, the current rate transition plan demands that many providers receive funding cuts in the face of increasing costs in order to help “balance” the rates of providers below the newly set rates. The classic case of robbing Peter to pay Paul will have a devastating impact on the provision of services for individuals with disabilities.

Second, by attempting to fit new rates within the current levels of appropriation, the state is forcing providers to operate within shockingly low wage estimates for arguably the most important employees in their organizations – Direct Support Professionals. With average wages set at \$14.08 in the residential system and \$14.75 in the day system, agencies are forced to drive starting wages ever-closer to the state’s new minimum wage for those individuals responsible for the care and support of some of our state’s most vulnerable individuals.

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Again, as within the behavioral health system, when disability providers are underfunded, there is a trickle-down impact to clients and the community. As providers have struggled to cope with increasing costs, a waiting list for services (in particular, residential) has grown to thousands across the state. For each of these individuals, this means remaining in the care of their parents, grandparents, siblings, or other guardians, many of whom must alter or eliminate their own work schedules to provide support. Often, this forces families to seek additional state-funded social services, as they are not able to provide their own insurance, medical benefits, or even funding for food.

Similarly, providers are forced to offer significantly low staff wages, compelling staff to work multiple jobs and rely on these same state-funded social services. Providers also often experience loss of committed staff members to jobs outside of the field, as employees move to places like major retailers simply because they can offer more competitive wages that will allow them to support their own families.

The rate transition process, as it currently stands, is pushing this issue to new levels, forcing providers to cut services, whether incrementally in hours per person, or in the form of entire service slots. This system wide instability is only likely to continue into the future, as rates of reimbursement will change each year as the needs/individuals in the system change. The transition process must be changed so that the most chronically underfunded providers who are currently “under-the-rate” receive the increases they need without cutting “over the rate” providers in the process, many of whom are barely staying afloat themselves.

Conclusion

Funding challenges to community providers are clear, serious, and dangerous. Underfunding a system already on the verge of collapse threatens the safety and well-being of Connecticut’s communities, providers’ employees, and the clients they serve. And while some observers may discount nonprofit providers’ claims that underfunding is driving them out of business, the state has now entered the era where this is reality. As administrative and operational costs have risen, providers have been forced to lay off staff, reduce employee benefits, keep positions vacant, and in some cases close programs. Again, there is a tipping point, and the state is there.

Despite the massive challenges faced by community-based providers, the services that they offer remain high quality, best practice-driven, and operated fully in the best interests of the individuals served. National trends have illustrated that community-based services are often the best option, and Connecticut’s reliance on the private provider system to deliver health and human services indicates the same. The state must prioritize the success of these services in order to adequately provide support to all of its residents.

While there may be multiple strategies to support the clients served by Connecticut’s community providers, the most obvious and effective is to provide funding that covers the cost of care:

- Medicaid reimbursement rates, whether in the form of CPT codes or per diem waiver-based rates, must be increased to reflect the current costs of appropriate levels of care. This must start with the legislature and Administration fulfilling legislative mandates for increased rates.
- State funding streams must remain intact to continue to support services during the transition. Notably, grants (primarily through DMHAS and DCF) are critical to a stable system of care, particularly in assessing the current system wherein Medicaid does not cover the full cost of care.
- OPM should conduct an analysis comparing the cost of state services used by community provider employees to the state budget savings in funding reductions for private providers, as they have recently expressed an interest in doing.
- To support the goal of cost-based funding for services, the state must consider ways to maximize federal reimbursement, again a win-win proposition. Services that are not reimbursed through current state Medicaid plans, but could be if negotiated appropriately at the federal level, should

be considered. Providers have often been turned down when attempting to find new ways to maximize their own agency's funding through innovative service delivery models, if such models do not fit within the current waiver structure.

Community providers are high quality businesses and service providers – they must be reimbursed for the true cost of the quality care and support they provide to Connecticut's most vulnerable citizens. In the absence of adequate funding, they will continue to face high turnover, layoffs, program closures and more. It is not rhetoric to state, without equivocation, that the state's system of care for its most vulnerable is facing destabilization if current funding trends continue. Without adequate funding, individuals, families, communities and the state economy will suffer enormous losses.

¹ "The Federal Medical Assistance Percentages (FMAPs) are used in determining the amount of Federal matching funds for State expenditures for assistance payments for certain social services, and State medical and medical insurance expenditures. The Social Security Act requires the Secretary of Health and Human Services to calculate and publish the FMAPs each year." (U.S. Department of Health and Human Services)